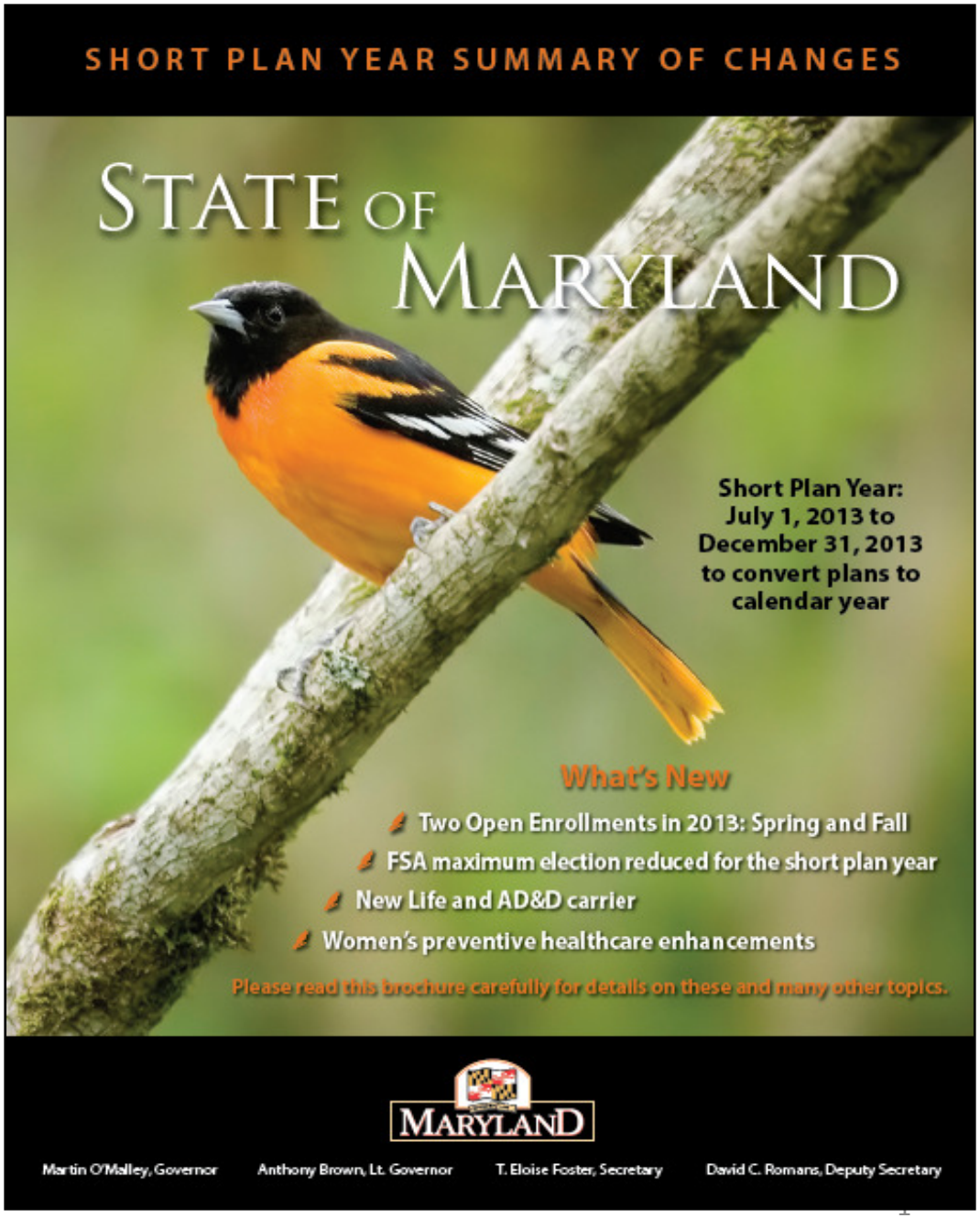
Short Plan Year 2013 Open Enrollment July 1, 2013 to December 31, 2013

MARYLAND

DEPARTMENT OF BUDGET & MANAGEMENT
Employee Benefits Division
301 West Preston Street
Room 510
Baltimore, MD 21201



Short Plan Year 2013

Covering July 1, 2013 – December 31, 2013

Open Enrollment

April 16, 2013 – April 30, 2013

Correction Period

May 8, 2013 – May 15, 2013

IMPORTANT:

This coming plan year will only be for six months.

Be sure to read the Open Enrollment materials mailed to your home or provided to you by your Agency Benefits Coordinator to learn how this short plan year affects your health benefits.

REMEMBER:

Open Enrollment is your opportunity to enroll in the benefit plans offered by the State of Maryland or to make changes to your current benefits coverage elections.

DETAILED OPEN ENROLLMENT INFORMATION IS AVAILABLE ON OUR WEBSITE AT:

www.dbm.maryland.gov/benefits

Department of Budget & Management

Employee Benefits Division

410.767.4775 or 1.800.307.8283 or EBDmail@dbm.state.md.us

PUTTING the PIECES TOGETHER

(You can scan this QR code to go directly to our website)

Open Enrollment Postcard

SHORT PLAN YEAR 2013 OE

Switching from a fiscal plan year to a calendar plan year.

- Open Enrollment:
  - April 16, 2013 to April 30, 2013
- Correction Period:
  - May 8, 2013 to May 15, 2013
- Forms due from agency:
  - By 4:00pm on May 22, 2013
- Short Plan Year Dates:
  - July 1, 2013 to December 31, 2013

SHORT PLAN YEAR 2013 OE

Open Enrollment packet distribution

- Mailing to retirees and direct pay on March 11, 2013
- Delivery to agencies starts on March 13, 2013

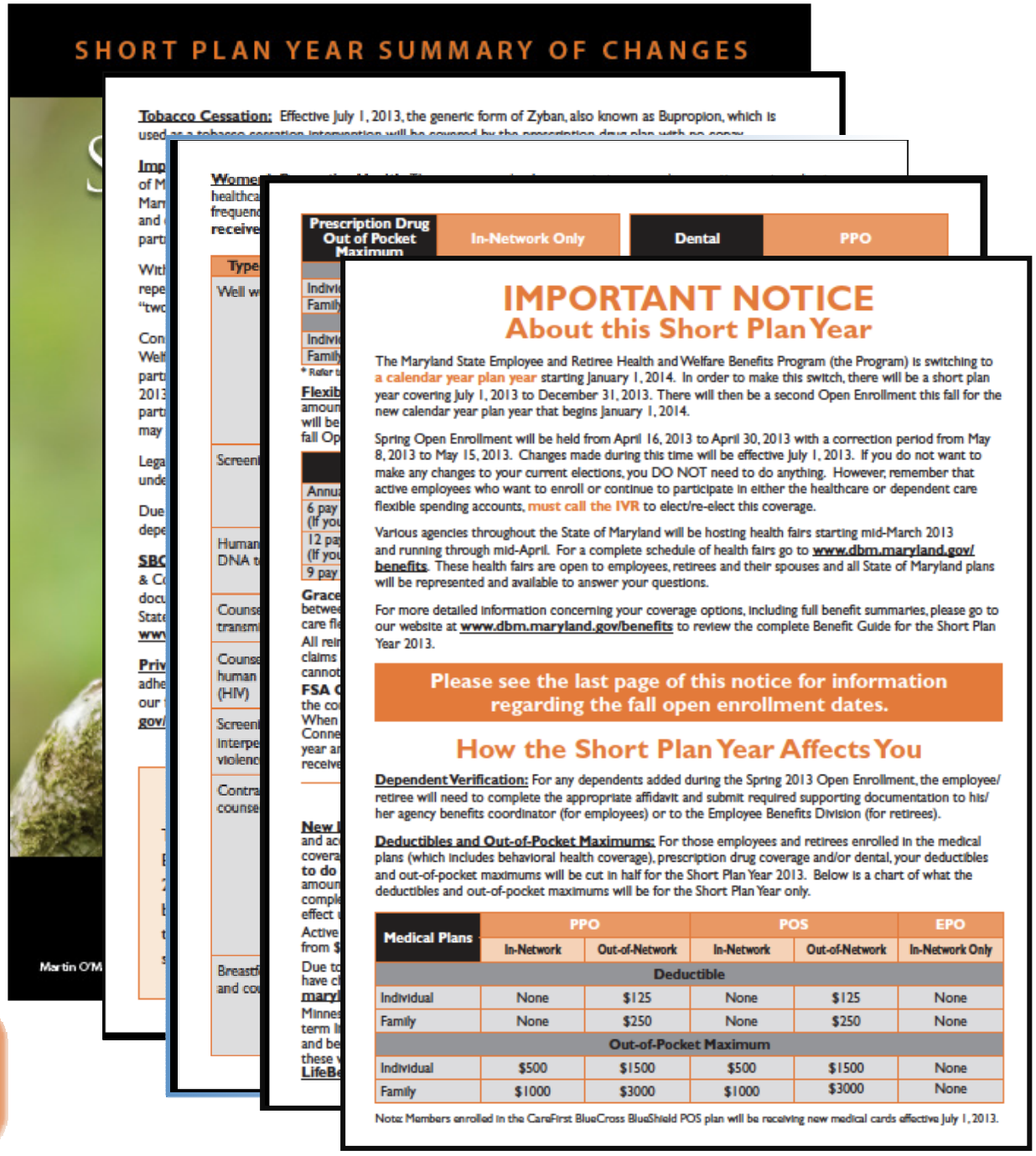
We are unable to accommodate special delivery arrangements will be made.

SHORT PLAN YEAR 2013 OE

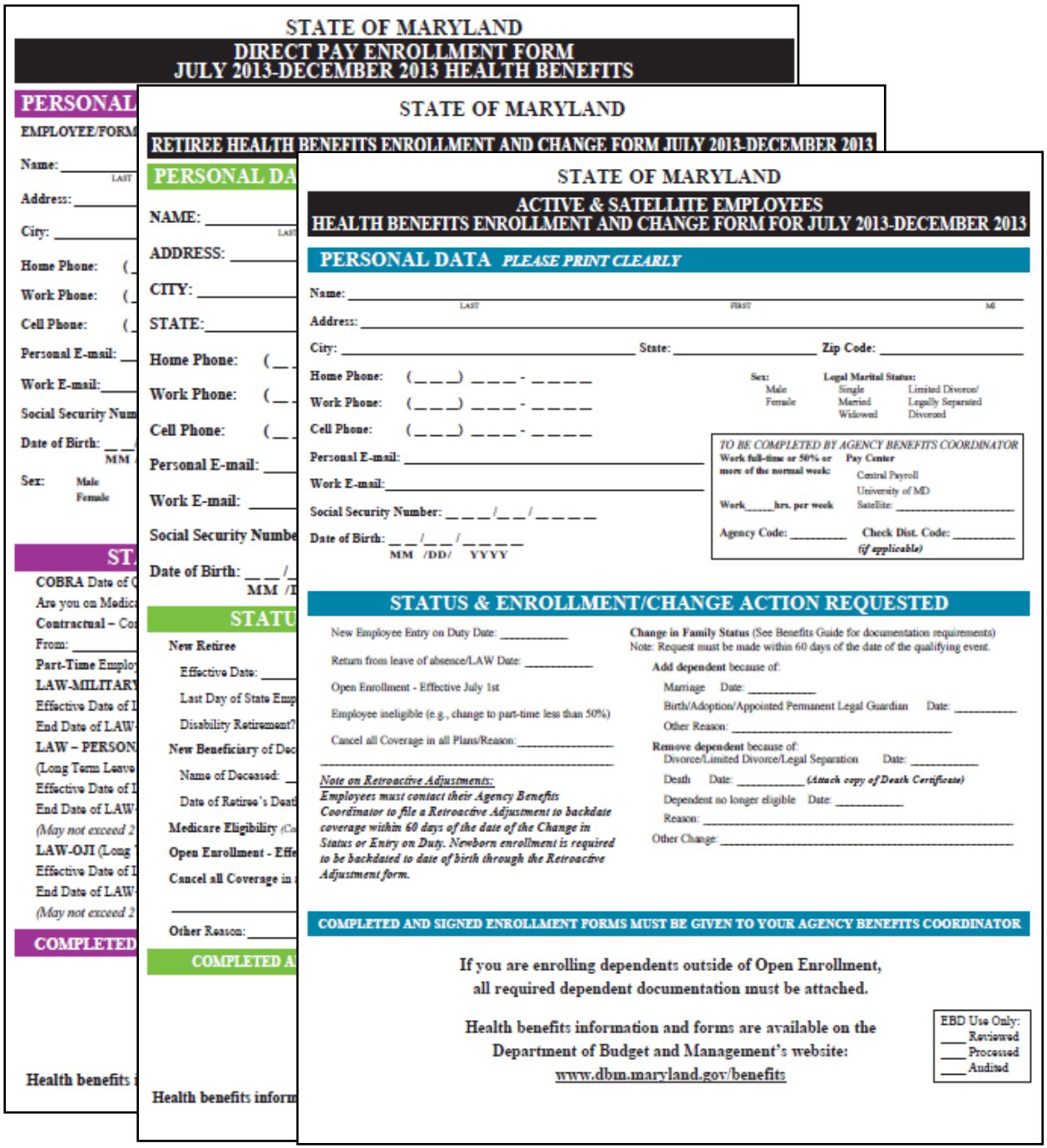
Rates

- Included in the packets
- Will be posted on the web by COB on March 13, 2013

The Open Enrollment Packet contains a Short Plan Year Summary of Changes instead of the full version of the Benefits Guide. The full version of the Benefits Guide is available online.



Click on the Benefits Guide Quick Link


STATE OF MARYLAND

DIRECT PAY ENROLLMENT FORM
JULY 2013-DECEMBER 2013 HEALTH BENEFITS

PERSONAL

STATE OF MARYLAND

RETIREE HEALTH BENEFITS ENROLLMENT AND CHANGE FORM JULY 2013-DECEMBER 2013

PERSONAL DA

STATE OF MARYLAND

ACTIVE & SATELLITE EMPLOYEES
HEALTH BENEFITS ENROLLMENT AND CHANGE FORM FOR JULY 2013-DECEMBER 2013

PERSONAL DATA *PLEASE PRINT CLEARLY*

Name: _____
LAST FIRST MI

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (___) ___-____

Work Phone: (___) ___-____

Cell Phone: (___) ___-____

Personal E-mail: _____

Work E-mail: _____

Social Security Number: ___/___/____

Date of Birth: ___/___/____
MM /DD/ YYYY

Sex: Male Female

Legal Marital Status: Single Married Widowed Limited Divorce/ Legally Separated Divorced

TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

Work full-time or 50% or more of the normal week: Work_____hrs. per week

Pay Center: Central Payroll / University of MD / SateElite: _____

Agency Code: _____ Check Dist. Code: _____ *(if applicable)*

STATUS & ENROLLMENT/CHANGE ACTION REQUESTED

New Employee Entry on Duty Date: _____

Return from leave of absence/LAW Date: _____

Open Enrollment - Effective July 1st

Employee ineligible (e.g., change to part-time less than 50%)

Cancel all Coverage in all Plans/Reason: _____

Note on Retroactive Adjustments:
Employees must contact their Agency Benefits Coordinator to file a Retroactive Adjustment to backdate coverage within 60 days of the date of the Change in Status or Entry on Duty. Newborn enrollment is required to be backdated to date of birth through the Retroactive Adjustment form.

Change in Family Status (See Benefits Guide for documentation requirements)
Note: Request must be made within 60 days of the date of the qualifying event.

Add dependent because of:
Marriage Date: _____
Birth/Adoption/Appointed Permanent Legal Guardian Date: _____
Other Reason: _____

Remove dependent because of:
Divorce/Limited Divorce/Legal Separation Date: _____
Death Date: _____ *(Attach copy of Death Certificate)*
Dependent no longer eligible Date: _____
Reason: _____
Other Change: _____

COMPLETED AND SIGNED ENROLLMENT FORMS MUST BE GIVEN TO YOUR AGENCY BENEFITS COORDINATOR

If you are enrolling dependents outside of Open Enrollment, all required dependent documentation must be attached.

Health benefits information and forms are available on the Department of Budget and Management's website: www.dbm.maryland.gov/benefits

EBD Use Only:
___ Reviewed
___ Processed
___ Audited

ENROLLMENT FORMS

Enrollment forms are now interactive. Members can simply download a form to their computer, complete, and print.

Enrollment Forms: click on Forms Tab

SHORT PLAN YEAR 2013 OE QUESTIONS

ENROLLMENT REFRESHER

- IVR (Interactive Voice Response) System
- Summary Statements
- Dependent Verification
- Social Security
- Enrollment Forms
- Nopay vs Retroactive Adjustment
- Health Benefits for Retirees
- Benefit Termination

IVR

- Please assist your employees with utilizing the IVR. Please DO NOT instruct them to call EBD.
- IVR Number:
  - Baltimore area: 410-669-3893
  - Outside Baltimore area: 1-888-578-6434

- Employee's Login Information
  - ID is employee's social security number
  - PIN is 4 digit number – month and day of employee's birthdate: mmdd

SUMMARY STATEMENTS

- ABCs print copies for their Active employees from the online BAS. Retirees and Direct Pay will receive in the mail from EBD.
- If an employee calls the IVR on Monday, entry to the Benefit Administration System will occur on Tuesday, and a new Summary Statement will be available on Wednesday.
- This helps the employees/retirees know if they correctly made their desired changes.
- ABCs need to review to know who needs to provide DVA documentation, EOI (Evidence of Insurability) documents, and/or social security numbers.

DEPENDENT VERIFICATION DOCUMENTATION

- "~" by a dependent's name on the summary statement indicates that an affidavit and verification documentation are needed.
- Gather the documentation and hold until requested by the EBD Auditing Unit in July 2013.

Affidavit: click on Forms Tab

IMPORTANCE OF SOCIAL SECURITY

- We are required to report to CMS using social security numbers as they monitor for double coverage between our plan and state or federally sponsored welfare programs such as Medicaid or CHIP.
- Please ensure you obtain social security numbers for employees/retirees and their dependents.

ENROLLMENT FORM

- Thoroughly review & sign form.
- DO NOT send to EBD if information is missing. Ensure form and all documentation is submitted within 60 days of the qualifying event change.
- Ensure appropriate and accurate documentation is attached as necessary.
- When you receive complete forms with all necessary documentation attachments, please send to EBD that same day. DO NOT hold.
- Keep a copy for your records

Enrollment Forms & Affidavit: click on Forms Tab

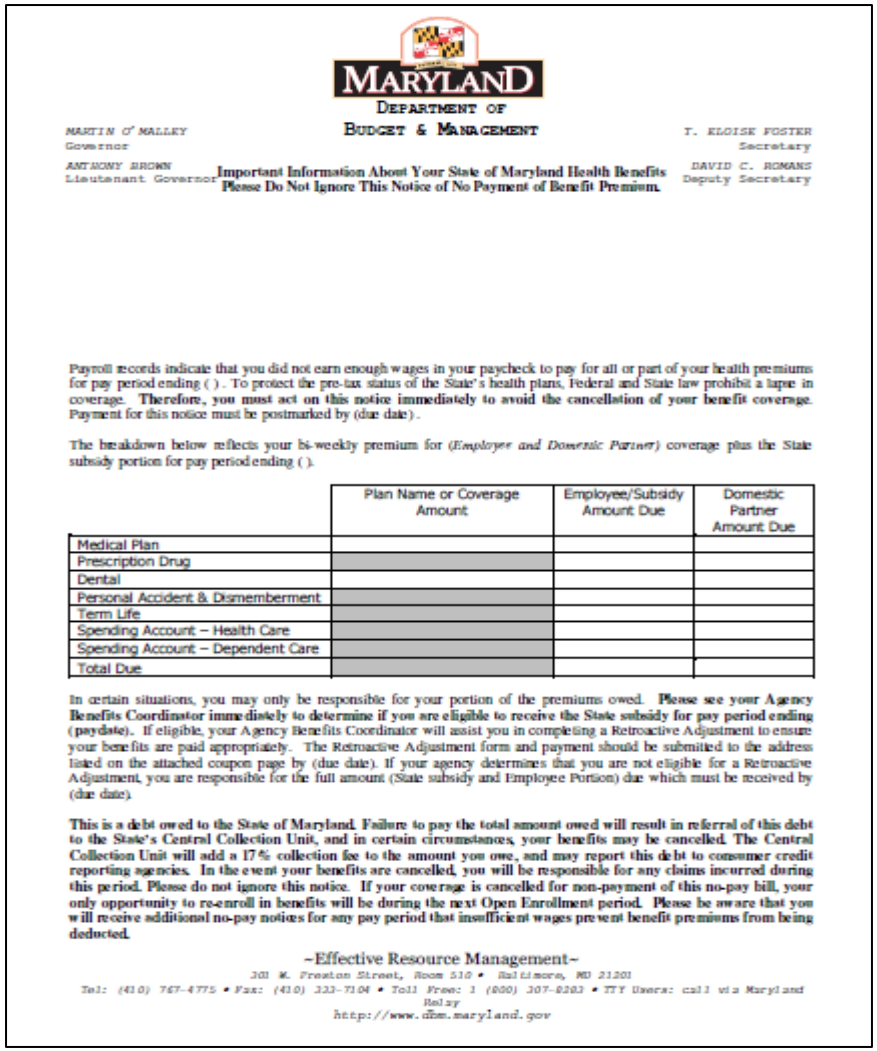
NO PAY VS RETROACTIVE ADJUSTMENT

- What is a No Pay?
  - Letter from EBD sent to member and ABC that member did not have some or all deductions taken from pay.
  - If member is responsible for full amount of premium (employee & state subsidy), should use coupon to pay.
  - If member is responsible to pay only the employee portion of the missed premium, member should see ABC to do a retroactive adjustment. Due of retroactive adjustment is the same date as indicated on the no pay letter.

NO PAY VS RETROACTIVE ADJUSTMENT

- What is a Retroactive Adjustment?
  - Member is only responsible for employee portion of premium.
  - Due to missed premiums
    - Voluntary: marriage, coverage backdated to start of employment, etc.
    - Mandatory: birth of a child; missed deductions due to transfers
  - Retroactive Adjustment form & member check MUST be mailed together to the PO box.

NO PAY LETTER



MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

MARTIN O'MALLEY
Governor

ANTHONY BROWN
Lieutenant Governor

T. ELOISE FOSTER
Secretary

DAVID C. ROMANS
Deputy Secretary

Important Information About Your State of Maryland Health Benefits
Please Do Not Ignore This Notice of No Payment of Benefit Premium.

Payroll records indicate that you did not earn enough wages in your paycheck to pay for all or part of your health premiums for pay period ending ( ). To protect the pre-tax status of the State's health plans, Federal and State law prohibit a lapse in coverage. **Therefore, you must act on this notice immediately to avoid the cancellation of your benefit coverage.** Payment for this notice must be postmarked by (due date).

The breakdown below reflects your bi-weekly premium for (*Employee and Domestic Partner*) coverage plus the State subsidy portion for pay period ending ( ).

	Plan Name or Coverage Amount	Employee/Subsidy Amount Due	Domestic Partner Amount Due
Medical Plan			
Prescription Drug			
Dental			
Personal Accident & Dismemberment			
Term Life			
Spending Account – Health Care			
Spending Account – Dependent Care			
Total Due			

In certain situations, you may only be responsible for your portion of the premiums owed. **Please see your Agency Benefits Coordinator immediately to determine if you are eligible to receive the State subsidy for pay period ending (paydate).** If eligible, your Agency Benefits Coordinator will assist you in completing a Retroactive Adjustment to ensure your benefits are paid appropriately. The Retroactive Adjustment form and payment should be submitted to the address listed on the attached coupon page by (due date). If your agency determines that you are not eligible for a Retroactive Adjustment, you are responsible for the full amount (State subsidy and Employee Portion) due which must be received by (due date).

This is a debt owed to the State of Maryland. Failure to pay the total amount owed will result in referral of this debt to the State's Central Collection Unit, and in certain circumstances, your benefits may be cancelled. The Central Collection Unit will add a 17% collection fee to the amount you owe, and may report this debt to consumer credit reporting agencies. In the event your benefits are cancelled, you will be responsible for any claims incurred during this period. Please do not ignore this notice. If your coverage is cancelled for non-payment of this no-pay bill, your only opportunity to re-enroll in benefits will be during the next Open Enrollment period. Please be aware that you will receive additional no-pay notices for any pay period that insufficient wages prevent benefit premiums from being deducted.

~Effective Resource Management~

301 W. Preston Street, Room 510 • Baltimore, MD 21201
Tel: (410) 767-4775 • Fax: (410) 333-7104 • Toll Free: 1 (800) 307-0203 • TTY Users: call via Maryland Relay
http://www.dbm.maryland.gov

If you have terminated State employment, you may be eligible to continue coverage under COBRA. If you owe any premiums as an Active employee at the time of termination, you will be responsible for payment prior to being enrolled for COBRA. For questions regarding COBRA coverage, please contact your Agency Benefits Coordinator or the Employee Benefits Divisions at 410 767-4775 and select Option 1.

You may disregard this notice **ONLY** if you are recently Retired, a current COBRA member, or on a Leave of Absence without Pay and currently paying your premium directly to the Employee Benefits Division via payment coupons.

If you have questions regarding this notice, please call our Customer Service Unit at 410-767-4775 and select Option 1 or see your Agency Benefits Coordinator located in your personnel office. Thank you.

Sincerely,

Employee Benefits Division

Cc: Agency Benefit Coordinator

No Payment Coupon

Return this portion with your payment by - Amount Due

Agency Code:
SSN:
PPE Date: NP 7

MAKE CHECK PAYABLE TO:
STATE OF MARYLAND
DEPT. OF BUDGET & MANAGEMENT

MAIL TO:
STATE OF MARYLAND, DBM
PO BOX 1516
BALTIMORE, MD 21203-1516

DOE	Plan	Amount

Total amount remitted with this coupon - $

NO PAY LETTER – KEY WORDING

In certain situations, you may only be responsible for your portion of the premiums owed. **Please see your Agency Benefits Coordinator immediately to determine if you are eligible to receive the State subsidy for pay period ending (paydate).** If eligible, your Agency Benefits Coordinator will assist you in completing a Retroactive Adjustment to ensure your benefits are paid appropriately. The Retroactive Adjustment form and payment should be submitted to the address listed on the attached coupon page by (due date). If your agency determines that you are not eligible for a Retroactive Adjustment, you are responsible for the full amount (State subsidy and Employee Portion) due which must be received by (due date).

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RETROACTIVE ADJUSTMENT

click on ABC Corner Tab

Department of Budget & Management
Employee Benefits Division
P.O. Box 1516
Baltimore, MD 21203-1516

RETRO-8A

I TO BE COMPLETED BY AGENCY BENEFITS COORDINATOR

EMPLOYEE'S NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ AGENCY CODE: _____

A. REASON FOR RETROACTIVE ADJUSTMENT

NEWBORN	DATE OF QUALIFYING EVENT: _____
MARRIAGE	DATE OF QUALIFYING EVENT: _____
NEW HIRE	DATE OF QUALIFYING EVENT: _____
TRANSFER	DATE OF QUALIFYING EVENT: _____
CUT OFF IN ERROR	DATE OF QUALIFYING EVENT: _____
LAW CHANGED TO PAID LEAVE	DATE OF QUALIFYING EVENT: _____
OTHER: _____	DATE OF QUALIFYING EVENT: _____

C: EMPLOYEE BALANCE: 0.00 CHECK NUMBER: _____

D: R*STARS TRANSFER AMOUNT: 0.00

Complete calculation on rever, have Fiscal Officer complete R*STARS information, attach employee's check for premiums due, paystubs, and no pay bill (if applicable) and mail to :
Department of Budget & Management, Employee Benefits Division, P.O. Box 1516, Baltimore, MD 21203-1516

Agency Benefit Coordinator Signature _____ Agency Benefit Coordinator Name _____

Agency Address _____

Agency Name _____ Agency Phone Number _____

Agency Benefit Coordinator email address _____

II. **MUST** BE COMPLETED BY AGENCY FISCAL OFFICER:

The state subsidy will be charged according to the following codes under the R*STARS system
Agency contribution:

AGENCY | PCA | TC | COMP/AGY OBJ

Retiree surcharge:

AGENCY | PCA | TC | COMP/AGY OBJ

Fiscal Officer Signature _____ Fiscal Officer Name & Phone Number _____

EMPLOYEE NAME _____ SOCIAL SECURITY NUMBER _____

PERIOD REQUIRING ADJUSTMENT:

FROM: _____ Date of Qualifying event

TO: _____ Last day covered by incorrect deduction. Please refer to schedule of pay periods

PAY PERIOD ENDING DATES REQUIRING ADJUSTMENT: _____

NUMBER OF PAY PERIODS: 0

HEALTH INSURANCE CARRIER: _____

COVERAGE LEVEL: OLD _____

NEW _____

If rates change because this adjustment overlaps FISCAL YEARS, use two calculation sheets.

EMPLOYEE CONTRIBUTION

			New Rate		Old Rate	=	Difference	*	Pay Periods	=	Total
040	Health	Pre-Tax	0.00	-	0.00	=	0.00	*	0	=	0.00
		Post-Tax	0.00	-	0.00	=	0.00	*	0	=	0.00
045	Prescription	Pre-Tax	0.00	-	0.00	=	0.00	*	0	=	0.00
		Post-Tax	0.00	-	0.00	=	0.00	*	0	=	0.00
048	Dental	Pre-Tax	0.00	-	0.00	=	0.00	*	0	=	0.00
		Post-Tax	0.00	-	0.00	=	0.00	*	0	=	0.00
052	PA&D		0.00	-	0.00	=	0.00	*	0	=	0.00
054	Life		0.00	-	0.00	=	0.00	*	0	=	0.00
	Additional Life		0.00	-	0.00	=	0.00	*	0	=	0.00
046	Spending Accounts										
	Health		0.00	-	0.00	=	0.00	*	0	=	0.00
	Dependnent		0.00	-	0.00	=	0.00	*	0	=	0.00
047	Long Term Care		0.00	-	0.00	=	0.00	*	0	=	0.00
											0.00

STATE CONTRIBUTION

	New Rate		Old Rate	=	Difference	*	Pay Periods	=	Total
Health	0.00	-	0.00	=	0.00	*	0	=	0.00
Prescription	0.00	-	0.00	=	0.00	*	0	=	0.00
Dental	0.00	-	0.00	=	0.00	*	0	=	0.00
									0.00

IMPUTED INCOME

	New Rate		Old Rate	=	Difference	*	Pay Periods	=	Total
Health	0.00	-	0.00	=	0.00	*	0	=	0.00
Prescription	0.00	-	0.00	=	0.00	*	0	=	0.00
Dental	0.00	-	0.00	=	0.00	*	0	=	0.00

RETROACTIVE ADJUSTMENT EXAMPLE

Scenario:

- 1/7/13 Member has baby (qualifying event date). Wants to add baby to health and prescription drug plans.
- 2/1/13 Member turns in completed enrollment form but does not include documentation.
- 2/15/13 gives you a copy of the birth certificate and affidavit.
- 2/20/13 ABC sends the completed form and documents to EBD.
- 2/22/13 EBD receives form. We are currently processing for a 3/16/13 effective date.
- 2/25/13: New Summary Statement now available. Retroactive adjustment can now be completed.
- **This Member needs a retroactive adjustment done from 1/1/13 to 3/15/13 (5 pay periods).**

RETROACTIVE ADJUSTMENT EXAMPLE

Refer to the Schedule of Pay Periods for number of pay periods the retro should be completed for based on the date of the qualifying event and the effective date of the change.

Schedule of Pay Periods: click on ABC Corner Tab

Benefits Year July 2012 - June 2013

Pay Period Ending Dates for Central Payroll Employees	Dates Worked During Pay Period	Actual Pay Dates	Effective Dates for Coverage by Pay Period Ending Dates
6/26/2012	***6/13/2012 – 6/26/2012***	***7/3/2012***	***No Deductions Taken***
7/10/2012	6/27/2012 – 7/10/2012	7/18/2012	7/01 – 7/15/2012
7/24/2012	7/11/2012 – 7/24/2012	8/01/2012	7/16 – 7/31/2012
8/07/2012	7/25/2012 – 8/07/2012	8/15/2012	8/01 – 8/15/2012
8/21/2012	8/08/2012 – 8/21/2012	8/29/2012	8/16 – 8/31/2012
9/04/2012	8/22/2012 – 9/04/2012	9/12/2012	9/01 – 9/15/2012
9/18/2012	9/05/2012 – 9/18/2012	9/26/2012	9/16 – 9/30/2012
10/02/2012	9/19/2012 – 10/02/2012	10/10/2012	10/01 – 10/15/2012
10/16/2012	10/03/2012 – 10/16/2012	10/24/2012	10/16 – 10/31/2012
10/30/2012	10/17/2012 – 10/30/2012	11/07/2012	11/01 – 11/15/2012
11/13/2012	10/31/2012 – 11/13/2012	11/20/2012	11/16 – 11/30/2012
11/27/2012	11/14/2012 – 11/27/2012	12/05/2012	12/01 – 12/15/2012
12/11/2012	11/28/2012 – 12/11/2012	12/19/2012	12/16 – 12/31/2012
12/25/2012	***12/12/2012 – 12/25/2012***	***1/02/2013***	***No Deductions Taken***
1/08/2013	12/26/2012 – 1/08/2013	1/16/2013	1/01 – 1/15/2013
1/22/2013	1/09/2013 – 1/22/2013	1/30/2013	1/16 – 1/31/2013
2/05/2013	1/23/2013 – 2/05/2013	2/13/2013	2/01 – 2/15/2013
2/19/2013	2/06/2013 – 2/19/2013	2/27/2013	2/16 – 2/28/2013
3/05/2013	2/20/2013 – 3/05/2013	3/13/2013	3/01 – 3/15/2013
3/19/2013	3/06/2013 – 3/19/2013	3/27/2013	3/16 – 3/31/2013
4/02/2013	3/20/2013 – 4/02/2013	4/10/2013	4/01 – 4/15/2013
4/16/2013	4/03/2013 – 4/16/2013	4/24/2013	4/16 – 4/30/2013
4/30/2013	4/17/2013 – 4/30/2013	5/08/2013	5/01 – 5/15/2013
5/14/2013	5/01/2013 – 5/14/2013	5/22/2013	5/16 – 5/31/2013
5/28/2013	5/15/2013 – 5/28/2013	6/05/2013	6/01 – 6/15/2013
6/11/2013	5/29/2013 – 6/11/2013	6/19/2013	6/16 – 6/30/2013

Subject to change.

HEALTH BENEFITS FOR RETIREES

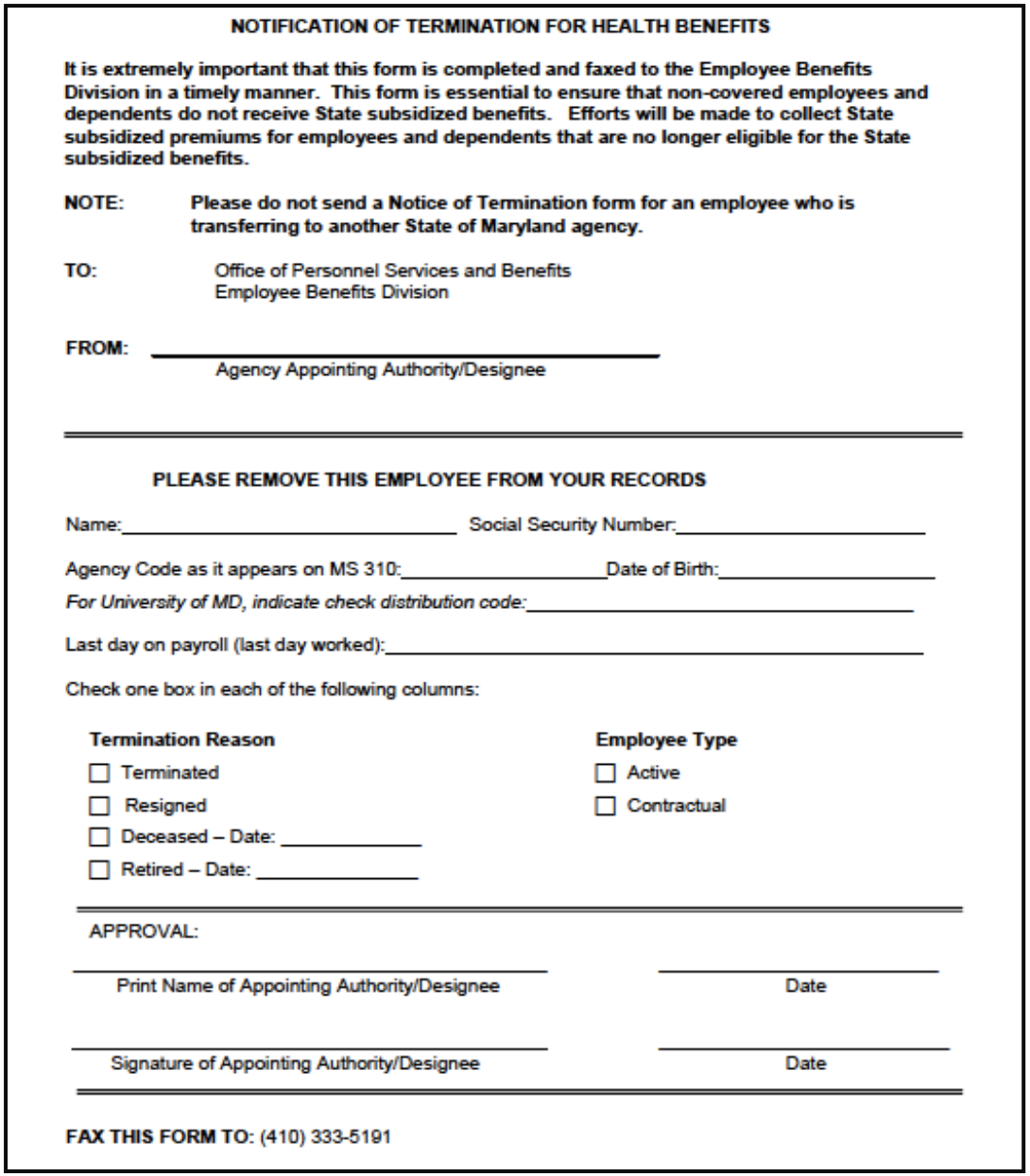
- All active employees who leave state service are termed and receive a COBRA notice regardless of their reason for leaving.
- For timely processing, notify SRA three (3) months prior to retirement.
- SRA must approve and enroll the retiree in their system before we can enroll the member in health benefits.
- Must complete a retiree health enrollment form.
- Retiree prescription drug benefits have a different out-of-pocket maximum than active employees.

Recommendation: Attend a pre-retirement seminar to better understand the retirement process and options.

TERMING BENEFITS

It is critical that we receive the Notification of Termination (NOT) in a timely manner as it affects member's claims, no pay process, processing of forms, and timely mailing of COBRA notices, etc.

NOTE: Need NOT even for employees who are retiring.



NOTIFICATION OF TERMINATION FOR HEALTH BENEFITS

It is extremely important that this form is completed and faxed to the Employee Benefits Division in a timely manner. This form is essential to ensure that non-covered employees and dependents do not receive State subsidized benefits. Efforts will be made to collect State subsidized premiums for employees and dependents that are no longer eligible for the State subsidized benefits.

NOTE: **Please do not send a Notice of Termination form for an employee who is transferring to another State of Maryland agency.**

TO: Office of Personnel Services and Benefits
Employee Benefits Division

FROM: _____
Agency Appointing Authority/Designee

PLEASE REMOVE THIS EMPLOYEE FROM YOUR RECORDS

Name:_____ Social Security Number:_____

Agency Code as it appears on MS 310:_____Date of Birth:_____

*For University of MD, indicate check distribution code:*_____

Last day on payroll (last day worked):_____

Check one box in each of the following columns:

Termination Reason
- ☐ Terminated
- ☐ Resigned
- ☐ Deceased – Date: _____
- ☐ Retired – Date: _____

Employee Type
- ☐ Active
- ☐ Contractual

APPROVAL:

_____ _____
Print Name of Appointing Authority/Designee Date

_____ _____
Signature of Appointing Authority/Designee Date

FAX THIS FORM TO: (410) 333-5191

PROBLEMS WHEN TERMING BENEFITS LATE

- If benefits are not termed timely, employees can still use services.
- This results in claims getting paid that should not have been covered.
- Audit unit then has to investigate and contact the vendor and possibly bill the member for those claims.

Note: Benefit premiums should not come out of the leave payout checks. Benefits must be termed based on the last day of work.

ENROLLMENT REFRESHER QUESTIONS

How does the Short Plan Year Affect You?

July 1, 2013 to December 31, 2013

DEDUCTIBLES & OUT-OF-POCKET MAXIMUMS

- Deductibles and Out-of-Pocket Maximums will be cut in half for the Short Plan Year.
- Applies to medical (PPO/POS), behavioral health, prescription drugs, and dental (DPPO).

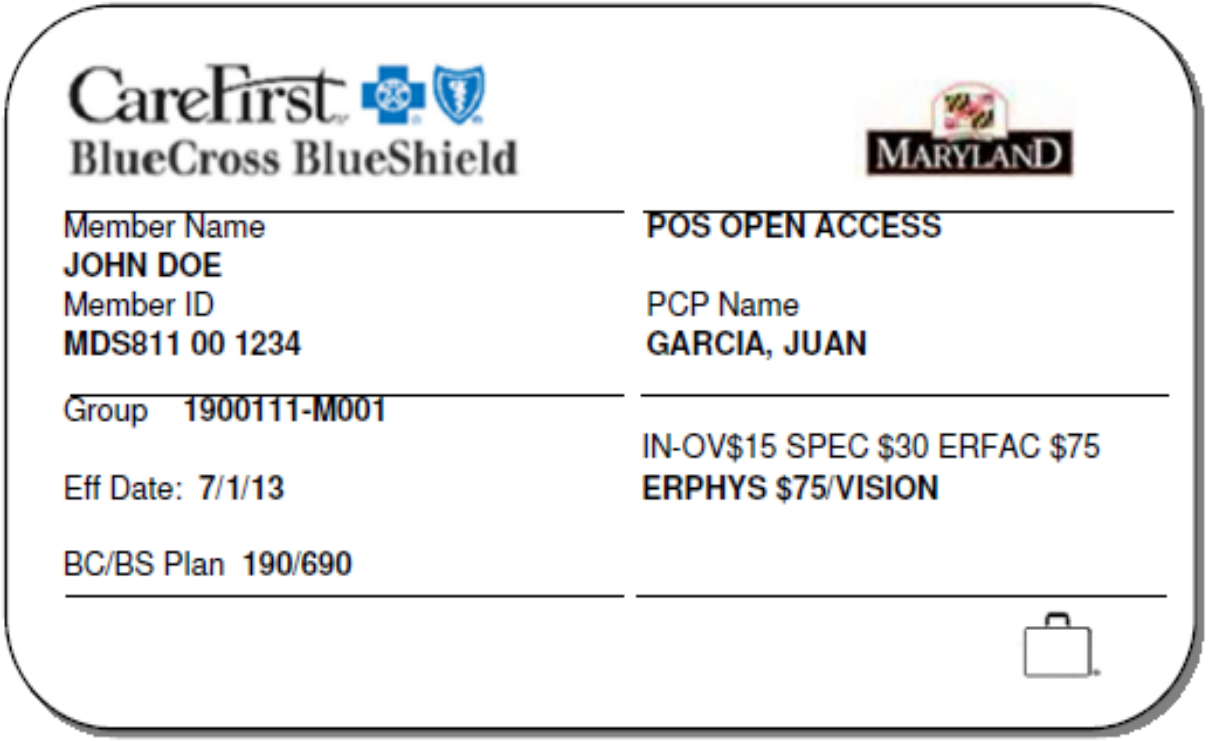
DEDUCTIBLES & OUT-OF-POCKET MAXIMUMS CHARTS

Medical Plans	PPO		POS		EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Deductible					
Individual	None	$125	None	$125	None
Family	None	$250	None	$250	None
Out-of-Pocket Maximum					
Individual	$500	$1500	$500	$1500	None
Family	$1000	$3000	$1000	$3000	None

Prescription Drug Out of Pocket Maximum	In-Network Only
Active Employees	
Individual	$500
Family	$750
Retirees	
Individual	$750
Family	$1000

Dental	PPO
Deductible (applies to Class II & Class III Services)	
Individual	$25
Family	$75
Plan Year Maximum	
Per Participant	$750

CAREFIRST POS PLAN



Members enrolled in the CareFirst POS plan will receive new cards effective July 1, 2013.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Changes in the minimum and maximum election amounts for the short plan year.

Pay Periods	Healthcare FSA		Dependent Care FSA	
	Minimum	Maximum	Minimum	Maximum
Annually	$60.00	$1,250.00	$60.00	$2,500.00
6 pay period deductions (If you are paid monthly)	$10.00	$208.33	$10.00	$416.66
12 pay period deductions (If you are paid bi-weekly)	$5.00	$104.16	$5.00	$208.33
9 pay faculty scheduled deductions	$6.66	$138.88	$6.66	$277.77

FLEXIBLE SPENDING ACCOUNTS (FSA) GRACE PERIOD

- Healthcare account participants can seek reimbursement for eligible items from July 1, 2013 to March 15, 2014.
- Dependent Day Care account participants can seek reimbursement for eligible services from July 1, 2013 to December 31, 2013.

FLEXIBLE SPENDING ACCOUNTS (FSA) CLAIMS SUBMISSION

- All claims incurred for both healthcare and dependent day care accounts must be submitted to CYC by April 15, 2014.
- If claims are not submitted by the deadline, the member will forfeit any amounts remaining in the FSA account(s).

FLEXIBLE SPENDING ACCOUNTS (FSA) PAYMENT CARD

- Card expires 3 years from the month of issue.
- CYC automatically sends a new card.

This is of particular note for 7/1/13. Any FSA participant who enrolled when CYC was first effective on 7/1/10 will be receiving a new debit card.

HOW DOES THE SHORT PLAN YEAR AFFECT YOU QUESTIONS

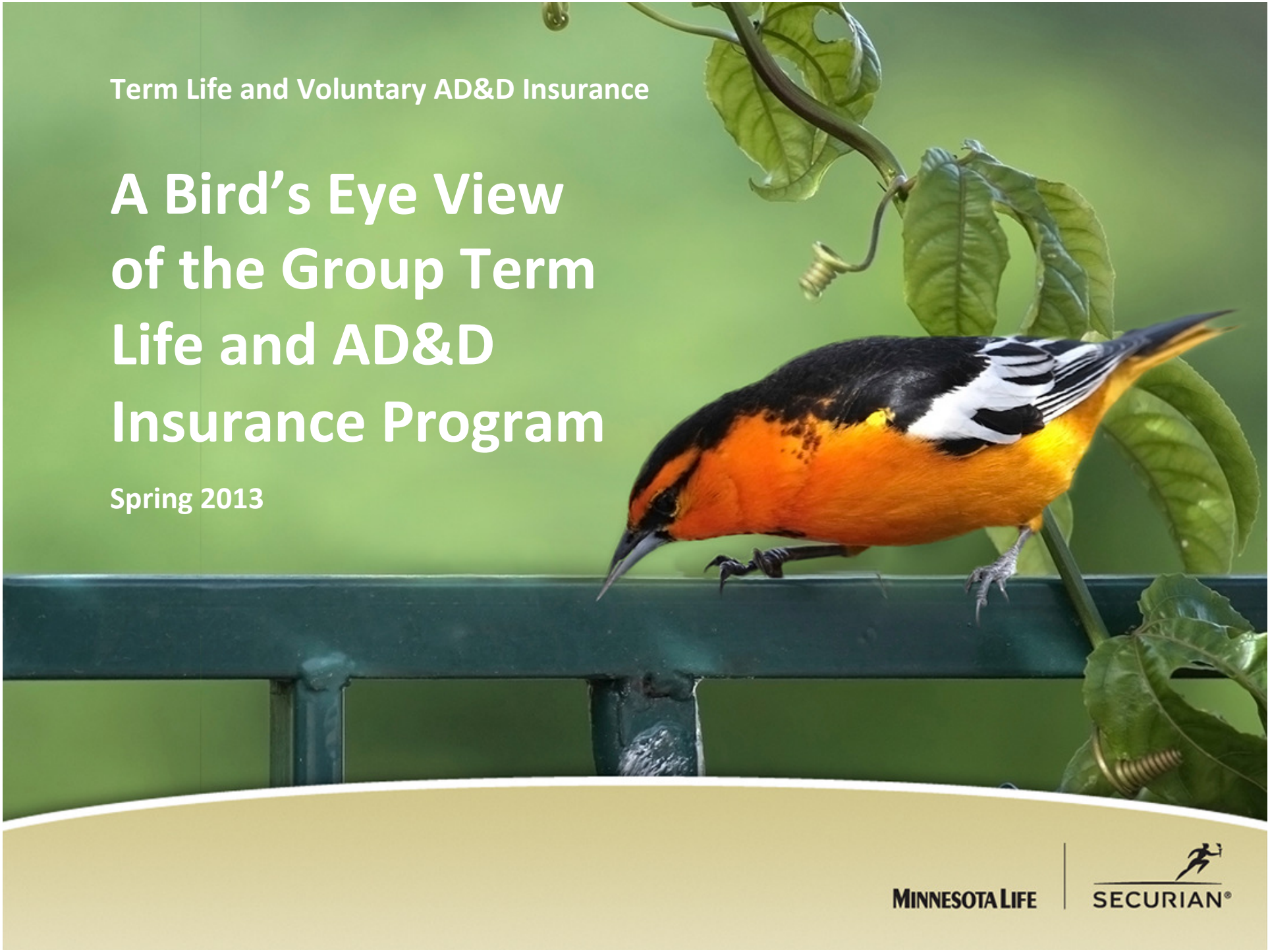
WHAT'S NEW AS OF JULY 1, 2013

- New Life and AD&D Carrier
- Women's Preventive Health Enhancements
- Tobacco Cessation
- Domestic Partner Coverage
- Summary of Benefits & Coverage

MINNESOTA LIFE

OUR NEW AD&D AND LIFE INSURANCE CARRIER

EFFECTIVE JULY 1, 2013



Term Life and Voluntary AD&D Insurance

A Bird's Eye View of the Group Term Life and AD&D Insurance Program

Spring 2013

MINNESOTA LIFE | SECURIAN®

Today's Topics

- Introduction to Minnesota Life
- Plan design overview
- Coverage overview
- Process flow
  - Evidence of Insurability (EOI)
  - Claims
  - Appeals
- LifeSuite services
- Resources

Minnesota Life

- New carrier effective July 1, 2013
- Providing group life insurance since 1917
- 17 state clients
- Highly rated
  - Minnesota Life is highly rated by the major independent rating agencies that analyze the financial soundness and claims-paying ability of insurance companies. For more information about the rating agencies and to see where our rating ranks relative to other ratings, please see our web site at www.securian.com/financials.

Plan design

- No coverage changes to the plan design:
  - Term Life
  - Spouse Term Life
  - Child Term Life
  - Voluntary Accidental Death & Dismemberment
- Change in rates, reference rate sheets for details
- Existing coverage transfers automatically
- No action from agency or employee required for transition
- Access to LifeSuite Services

Employee Term Life

Class 1

$10,000 increments, up to $300,000

Class 2

$10,000 increments, up to $500,000

- Class 1: All active employees that are not classified as class 2 employee
- Class 2: Active employees who fly in a helicopter, scuba dive, or are involved in other high risk services in the course of their employment with the State
- Employees must elect Term Life in order to elect coverage for spouse and/or child(ren)
- Guaranteed coverage (up to $50,000 maximum) available at initial eligibility, annual enrollment, and family status changes

Term Life for Dependents

Spouse

$5,000 increments, up to $150,000

Child

$5,000 increments, up to $150,000

- Dependent coverage cannot exceed 50% of member's Life amount
- No dual coverage
- Children are eligible from live birth up to age 26
- Guaranteed coverage (up to $25,000 maximum) available at initial eligibility, annual enrollment, and family status changes

Voluntary AD&D

Employee Plan

- $100,000
- $200,000
- $300,000

Family Plan

- Spouse (w/children): 55%
- Spouse only: 65%
- Child (w/spouse): 15%
- Child only: 25%

2013 Special Opportunity

Term Life	Spouse Life	Child Life
• $50,000 guaranteed coverage maximum	• $25,000 guaranteed coverage maximum	• $25,000 guaranteed coverage maximum

- April 16 – April 30, 2013
- Available for current participants and members enrolling for the first time.
- Coverage amounts over the guaranteed maximums and/or elected after April 30, 2013 will require EOI.

Continuing Coverage

If an employee is no longer eligible for coverage as an active employee, coverage may be continued, and premiums paid directly to Minnesota Life.

- May port Term Life, Spouse Term Life, Child Term Life, and Voluntary AD&D
- Cost is more than for active coverage
- Elect within 31 days of last date of employment
- EOI is not required

Continuing Coverage

If an employee is no longer eligible for coverage as an active employee, OR ported coverage has terminated, coverage may be converted to an individual life policy.

- May convert Term Life, Spouse Term Life, & Child Term Life
- Cost is more than for active coverage
- EOI is not required
- Elect within 31 days of last date of employment
- Premiums paid directly to Minnesota Life

Medical Underwriting

- Employees will be contacted directly by Minnesota Life
- Online process: www.LifeBenefits.com/Maryland
- Approval or denial confirmation to employee and Employee Benefits Division
- Employee Benefits Division processes approved coverage according to current EOI processing rules

Medical Underwriting

- Important dates regarding coverage elected by newly hired employees:
  - **May 26** is the last day to use previous carrier's Statement of Health Form
  - **May 27** begin using Minnesota Life's online process or EOI Form
- Coverage requiring EOI will become effective on 7/1 or on the date it is approved, whichever comes later.

Claims Process

- Beneficiary/member notifies MN Life by calling 1-866-883-3514
- MN Life contacts EBD for coverage verification
- MN Life sends Condolence Letter and paperwork to beneficiary
- Beneficiary returns completed forms and certified death certificate to MN Life
- MN Life provides decisions on pending claim
- Similar process used for *Waiver of Premium* and *Accelerated Death Benefit*

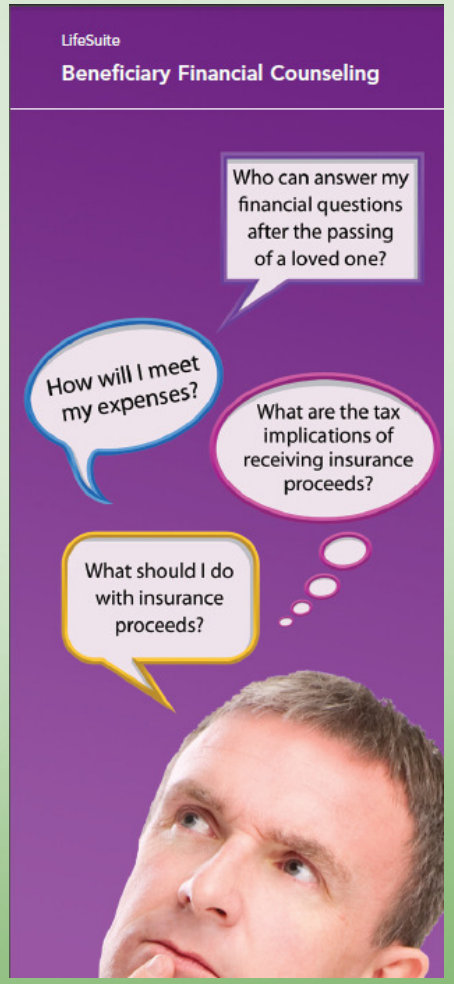
LifeSuite Services

1. Beneficiary Financial Counseling
2. Travel Assistance
3. Legal Services
4. Legacy Planning Services

- Access Basic services automatically, no additional actions required
- Offered in conjunction with Employee Term Life insurance
  - Not available with ported or converted coverage
- Available to insurance-eligible dependents
- Dependents do not have to be insured
- Responsibility of each service carrier
- Services not a part of any policy of insurance, and may be discontinued at any time
- Certain terms and conditions may apply

Beneficiary Financial Counseling

- Provider: PricewaterhouseCoopers LLP
- Invitation included in claim check
- Complimentary financial counseling
- No sales to your beneficiary



Travel Assistance

- Provider: Global Rescue
- 24-hour emergency travel service
- Travel for business or pleasure
- Dependents traveling without employee
- 100 miles or more away from home
- Locate physician, dentist, western-medicine facilities, etc.
- Secure language interpreter, the return of mortal remains, etc.

Legal Services

- Provider: Ceridian
- Online library of legal resources
- Develop simple wills, trusts, power-of-attorney
- National network of 22,000 attorneys
- 30-minute free consultation
- 25% discount for charged services

Legacy Planning Services

- www.LegacyPlanningServices.com
- Legacy planning
- Final arrangements
- Easy access to resources

Resources

- Online Information
  - www.dbm.maryland.gov/benefits
  - www.LifeBenefits.com/Maryland
- Printed Publications
  - State of Maryland Benefits Guide
  - Various fliers for health fairs (i.e. the importance of selecting a beneficiary)
- Phone
  - Minnesota Life: 1-866-883-3514

Questions?

Thank you for your time!

Do you have any questions?

This is a summary of plan provisions related to the insurance policy issued by Minnesota Life to the State of Maryland. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations, and terms of coverage. Products offered under policy form series numbers 13-31481 and 13-31487.

Services provided by Ceridian, Global Rescue LLC, and PricewaterhouseCoopers LLP are their sole responsibility. The services are not affiliated with Minnesota Life or its group contracts and may be discontinued at any time. Certain terms, conditions and restrictions may apply when utilizing the services.

Minnesota Life Insurance Company
A Securian Company

Group Insurance
www.LifeBenefits.com

400 Robert Street North, St. Paul, MN 55101-2098
F78524-1 1-2013
A00635-0213


BREAK
11
10

WOMEN'S PREVENTIVE HEALTH

- Enhancements are due to healthcare reform
- Services are provided at no cost to our members as long as they are received from an in-network provider.

WELL WOMAN VISITS

- Coverage
  - Age and developmentally appropriate preventive services
  - Includes preconception counseling, prenatal care (routine obstetrical office visits, recommended immunizations, tobacco cessations counseling), preventive mammograms, and immunizations.
- Frequency
  - One per plan year or
  - As necessary based on a woman's health status, needs, and risk factors.

COUNSELING & SCREENINGS

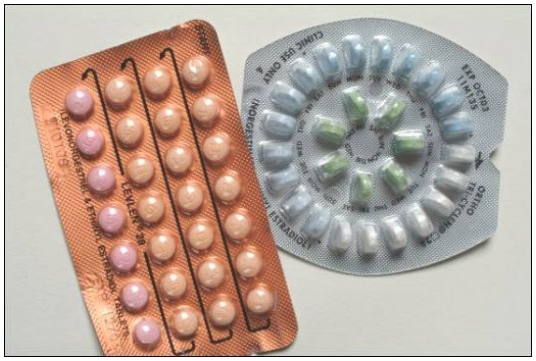
- Screening for gestational diabetes
  - during 24 to 26 weeks of pregnancy and at first prenatal visit for high risk pregnant women
- HPV DNA testing
  - once every 3 years after age 30
- Counseling for sexually transmitted infections
- Counseling & screening for HIV
- Screening & counseling for interpersonal and domestic violence

CONTRACEPTION METHODS

COVERED WITH ZERO COST SHARE TO THE MEMBER

PRESCRIPTION DRUG PLAN:

- Generic Oral Contraceptives
- Diaphragm
- Levonorgestrel (Generic Plan B)



MEDICAL PLAN:

- IUDs
- Tubal Ligation

BREASTFEEDING SUPPORT, SUPPLIES & COUNSELING

- Covers the cost for certain breastfeeding equipment.
  - This particular mandate is open to interpretation by the health plans as to what will be covered and how. We are ironing out the details with our health plans and will have this solidified and claim ready for 7/1/13.
- Equipment must be obtained by the member through their medical carrier's durable medical equipment partner(s).
- Does not cover breastfeeding supplies such as tubing, pads, or containers.

TOBACCO CESSATION

- Generic form of Zyban (Bupropion) used as a tobacco cessation intervention
- Will be available through the zero dollar copayment for generic drugs program offered by our prescription drug carrier.

SAME SEX SPOUSE

- MD Civil Marriage Protection Act effective January 1, 2013.
- Marriage recognized and allowed in MD for both opposite and same sex couples.
- Same sex spouse and dependents of the same sex spouse will still be subject to post tax benefits and imputed income unless they are true tax dependents of the employee. This is due to federal tax regulations.

SAME SEX DOMESTIC PARTNERS

- No new domestic partner enrollments after June 30, 2013.
- Currently enrolled domestic partners may add their child to the plan for the short plan year (during open enrollment or with an applicable qualifying event).
- Same sex domestic partners and their dependent children enrolled as of June 30, 2013 are eligible for coverage through December 31, 2013.
- In order to continue coverage beyond December 31, 2013, couple must be legally married. Will need updated affidavit and a copy of the marriage certificate.

Affidavit: click on Forms Tab

SUMMARY OF BENEFITS & COVERAGE (SBC)

- Healthcare reform requirement.
- Plan is required to provide a customized SBC for each plan type and coverage level.
- Helps members to compare plan options.
- Are available on EBD website.

Click Summary of Benefits & Coverage tab

SUMMARY OF BENEFITS & COVERAGE (SBC)

State of Maryland – CareFirst BlueCross BlueShield

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 7/1/2013 – 12/31/2013

Coverage level: Employee/Retiree & Family | **Plan Type:** PPO

This is only a summary. Due to the Short Plan Year coverage period (so the State can change to a calendar year), all deductibles and out-of-pocket limits are cut in half to accommodate the six month timeframe. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan documents at www.dbm.maryland.gov/benefits or by calling 410-767-4775 or 1-800-307-8283.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per plan year: In-Network: **None** Out-of-Network: **$125** per Individual/ **$250** per Family Does not include copays and is separate from coinsurance.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you receive out-of-network. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	In-network: **$500** per Individual / **$1,000** per Family; Out-of-network: **$1,500** per Individual / **$3,000** per Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for healthcare expenses.
What is not included in the out–of–pocket limit?	Premium, copayments, **balance-billed** charges, healthcare not covered under this plan and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.carefirst.com/statemd or call 800-225-0131.	If you use an in-network doctor or other healthcare provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan. However, your costs will be different for an in-network specialist than an out-of-network specialist.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

Questions: Call 410-767-4775 or 1-800-307-8283 or email us at EBDMAIL@dbm.state.md.us or visit us at www.dbm.maryland.gov/benefits
If you aren't clear about any of the bolded & underlined terms used in this form, see the Glossary at www.dbm.maryland.gov/benefits

SUMMARY OF BENEFITS & COVERAGE (SBC)

State of Maryland – CareFirst BlueCross BlueShield

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 7/1/2013 – 12/31/2013

Coverage level: Employee/Retiree & Family | **Plan Type:** PPO

- **Copayments** (copays) are fixed dollar amounts (for example, $15) you pay for covered healthcare, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight in-network hospital stay is $1,000, your **coinsurance** payment of 10% would be $100
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	30% coinsurance after deductible	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	$30 copay	30% coinsurance after deductible	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Other practitioner office visit	Acupuncture & Chiropractic: $20 copay	30% coinsurance after deductible	Acupuncture is only covered for chronic pain management. Preauthorization required
	Preventive care/screening/immunization	No Charge	30% coinsurance after deductible	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance after deductible	none
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance after deductible	none

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SUMMARY OF BENEFITS & COVERAGE (SBC)

State of Maryland – CareFirst BlueCross BlueShield

Coverage Period: 7/1/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage level: Employee/Retiree & Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or by calling 1-877-213-3867.	Generic drugs	$10 copay (1-45 day supply); $20 copay (46-90 day supply)	Not Covered	**Outpatient Prescription Drug coverage is not included in your medical plan.** You elect this coverage separately from your medical plan. The plan is administered by Express Scripts; you receive a separate ID card and pay a separate premium for prescription coverage. Review the State of Maryland's website at www.dbm.maryland/benefits for more details.
	Preferred brand drugs	$25 copay (1-45 day supply); $50 copay (46-90 day supply)	Not Covered	
	Non-preferred brand drugs	$40 copay (1-45 day supply); $80 copay (46-90 day supply)	Not Covered	
	Specialty drugs	Copay and drug supply limit varies by type of drug.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance after deductible	Must be preauthorized by plan.
	Physician/surgeon fees	10% coinsurance	30% coinsurance after deductible	Must be preauthorized by plan.
If you need immediate medical attention	Emergency room services	Facility: $75 copay Physician: $75 copay	Facility: $75 copay Physician: $75 copay	Copay waived if admitted. If criteria are not met for a medical emergency, the plan coverage is 50% after copays.
	Emergency medical transportation	No Charge	No Charge	Non-emergency use: 10% coinsurance in-network; 30% coinsurance out-of-network.
	Urgent care center	$30 copay	30% coinsurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance after deductible	Preauthorization required 20% non-compliance penalty
	Physician/surgeon fee	10% coinsurance	30% coinsurance after deductible	

Questions: Call 410-767-4775 or 1-800-307-8283 or email us at EBDMAIL@dbm.state.md.us or visit us at www.dbm.maryland.gov/benefits
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SUMMARY OF BENEFITS & COVERAGE (SBC)

State of Maryland – CareFirst BlueCross BlueShield

Coverage Period: 7/1/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage level: Employee/Retiree & Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay per visit	30% coinsurance after deductible	Behavioral health benefits are administered by APS Healthcare; You must be enrolled in the medical plan in order to have these benefits. You will receive a separate ID card for this coverage.
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance after deductible	
	Substance use disorder outpatient services	$15 copay per visit	30% coinsurance after deductible	
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance after deductible	
If you are pregnant	Prenatal and postnatal care	No Charge	30% coinsurance after deductible	Additional copays or preauthorization requirements may apply to postnatal care.
	Delivery and all inpatient services	10% coinsurance	30% coinsurance after deductible	Additional copays, deductible, co-insurance or notification requirements may apply.
If you need help recovering or have other special health needs	Home healthcare	10% coinsurance	30% coinsurance after deductible	Limited to 120 days per plan year.
	Rehabilitation services	$30 copay per visit	30% coinsurance after deductible	Limited to 50 combined visits per plan year for Speech, Occupational, and Physical Therapy. Must be preauthorized by plan.
	Habilitative services	$30 copay per visit	30% coinsurance after deductible	No limit of treatment for children under 19 with congenital or genetic birth defects including autism, autism spectrum disorder, and cerebral palsy. Must be preauthorized by plan. Over age 19 members visits are limited to 50 combined visits for therapies.

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SUMMARY OF BENEFITS & COVERAGE (SBC)

State of Maryland – CareFirst BlueCross BlueShield Coverage Period: 7/1/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage level:** Employee/Retiree & Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs (continued)	Skilled nursing care	10% coinsurance	30% coinsurance after deductible	Limited to 180 days per plan year. Must be preauthorized by plan.
	Durable medical equipment	10% coinsurance	30% coinsurance after deductible	Preauthorization required if over $1,000.
	Hospice service	10% coinsurance	30% coinsurance after deductible	Must be preauthorized by plan.
If your child needs dental or eye care	Eye exam	No charge - Up to a maximum of $45	No charge - Up to a maximum of $45	Coverage is limited to one routine eye exam per plan year up to $45. Non-routine eye exam copay is $15 per visit.
	Glasses	Please refer to your contract or the online Benefits Guide for coverage details.	Please refer to your contract or the online Benefits Guide for coverage details.	Frames: Plan pays $45 once per plan year; Member pays balance.
	Dental check-up	Covered under separate dental plan. Two types are offered: dental HMO and dental PPO	Out-of-network coverage available under the DPPO plan only.	Dental benefits are administered by United Concordia; you receive a separate ID card and pay a separate premium for dental coverage. **You must enroll in one of the dental plans to have dental coverage.** For more information call United Concordia at 1-888-638-3384 or www.unitedconcordia.com/statemd.

Questions: Call 410-767-4775 or 1-800-307-8283 or email us at EBDMAIL@dbm.state.md.us or visit us at www.dbm.maryland.gov/benefits
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SUMMARY OF BENEFITS & COVERAGE (SBC)

Excluded Services & Other Covered Services:

Services Your Medical Plan Does NOT Cover. (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Routine Dental care (Adult/Child)
- Long-term care
- Weight loss programs (Nutritional counseling is covered)
- Outpatient prescription drug
- Routine foot care

Other Covered Medical Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Immunization & preventative screenings (covered in full in-network only)
- Bariatric surgery
- Home healthcare
- Hearing aids covered once every 36 months with limitations
- Infertility Treatment – Artificial insemination and In vitro. Infertility treatment limited to 3 attempts, not to exceed a $100,000 lifetime maximum. Other restrictions apply. Refer to your policy and plan documents or the online benefits guide.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Employee Benefits Division at 1-800-307-8283. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Employee Benefits Division at 410-767-4775, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, the Office of Health Insurance Consumer Assistance can help you file an **appeal**. Contact information: 1-877-261-8807; heau@oag.state.md.us; or http://www.oag.state.md.us/Consumer/HEAU.htm

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

SUMMARY OF BENEFITS & COVERAGE (SBC)

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,850
- **Patient pays** $690

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Medical Copayment	$0
Prescription Copayment	$20
Coinsurance	$520
Limits or exclusions	$150
Total	**$690**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,630
- **Patient pays** $770

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Medical Copayment	$150
Prescription Copayment	$400
Coinsurance	$140
Limits or exclusions	$80
Total	**$770**

The coverage examples are based on the experience of one covered member or dependent regardless of coverage level.

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SUMMARY OF BENEFITS & COVERAGE (SBC)

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as flexible spending accounts (FSAs) that help you pay out-of-pocket expenses.

Questions: Call 410-767-4775 or 1-800-307-8283 or email us at EBDMAIL@dbm.state.md.us or visit us at www.dbm.maryland.gov/benefits
If you aren't clear about any of the bolded & underlined terms used in this form, see the Glossary at www.dbm.maryland.gov/benefits

WHAT'S NEW QUESTIONS

WHAT TO CONSIDER WHEN SELECTING A MEDICAL PLAN…

- The Network of Physicians
- Your personal preference on the ability to see doctors who do not participate in the network
- Which services require pre-authorization
- Vision Care benefits
- What is important to YOU? (mobile applications, robust wellness services, certain discount programs, etc.)

*Benefits not specifically outlined in the SOM RFP may be covered differently by each carrier. Members should contact carriers or refer to the formal contract documents on the EBD website for detailed coverage information.

WHAT TO CONSIDER WHEN SELECTING A MEDICAL PLAN…

- Each carrier has their own network of available physicians and hospitals

	PPO	POS	EPO
Aetna	Not Available	National Network of Drs In- and Out-of-Network Choice International Network Available	National Network of Drs In-Network Doctors Only No International Network
CareFirst	National Network of Drs In- and Out-of-Network Choice International Network Available	Regional Network of Drs In- and Out-of-Network Choice No International Network	National Network of Drs In-Network Doctors Only International Network Available
United Healthcare	National Network of Drs In- and Out-of-Network Choice International Network Available	National Network of Drs In- and Out-of-Network Choice International Network Available	National Network of Drs In-Network Doctors Only No International Network

IMPORTANT DEFINITIONS

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Plan Year Deductible Individual Family	None None	$125 $250	None None	$125 $250	None None
Out-of-Pocket Coinsurance & Deductible Maximum Individual Family	$500 $1,000	$1,500 $3,000	$500 $1,000	$1,500 $3,000	None None
	Any charges above the plan's Allowed Benefit are not counted toward the out-of-pocket maximum.				
Lifetime Maximum	Unlimited				
National Network	Yes	Yes	Yes	Yes	Yes
Primary Care Physician Required	No	No	No	No	Yes

• PPO (Preferred Provider Organization) – A PPO is a health insurance plan that utilizes a network of physicians and facilities contracted by the insurance carrier to provide services within negotiated price boundaries. PPO members have the option to use physicians and facilities that are not part of the network, but their out of pocket costs will be significantly higher.

• POS (Point of Service) – A POS plan is like a hybrid between a PPO and an HMO. Members use a network of physicians and facilities to seek care, but also have the ability to see providers outside of the network.

• EPO (Exclusive Provider Organization) – An EPO is a type of managed care plan. The EPO uses a network of providers from which a member must choose. EPO members are restricted to using In-Network providers only.

IMPORTANT DEFINITIONS

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Plan Year Deductible					
Individual	None	$125	None	$125	None
Family	None	$250	None	$250	None
Out-of-Pocket Coinsurance & Deductible Maximum					
Individual	$500	$1,500	$500	$1,500	None
Family	$1,000	$3,000	$1,000	$3,000	None
	Any charges above the plan's Allowed Benefit are not counted toward the out-of-pocket maximum.				
Lifetime Maximum	Unlimited				
National Network	Yes	Yes	Yes	Yes	Yes
Primary Care Physician Required	No	No	No	No	Yes

• In-Network – Services provided by a Participating Provider or facility.

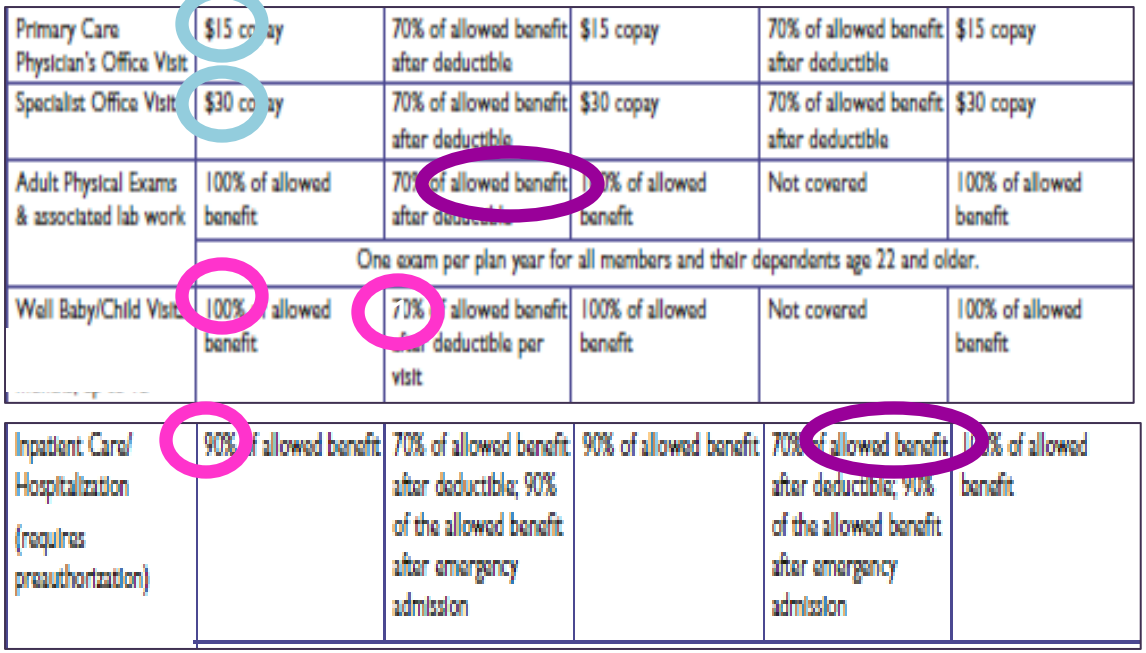
• Out-of-Network – Services received from providers outside of the plan's network. Such services are subject to up-front deductibles and coinsurance

• Deductible – The amount a member is required to pay before payment for services are paid for out-of-network treatment

• Out-of-Pocket Maximum (OOP)– This is the most a member will pay out of his or her pocket in coinsurance charges. The deductible is included in the OOP maximum. Copays are not included in the OOP maximum.

IMPORTANT DEFINITIONS

• Copayment – The flat dollar amount a member pays at the time service is rendered. Copays vary by type of service.



Primary Care Physician's Office Visit	$15 co ay	70% of allowed benefit after deductible	$15 copay	70% of allowed benefit after deductible	$15 copay
Specialist Office Visit	$30 co ay	70% of allowed benefit after deductible	$30 copay	70% of allowed benefit after deductible	$30 copay
Adult Physical Exams & associated lab work	100% of allowed benefit	70% of allowed benefit after	% of allowed benefit	Not covered	100% of allowed benefit
	One exam per plan year for all members and their dependents age 22 and older.				
Well Baby/Child Visit	100% allowed benefit	70% allowed benefit deductible per visit	100% of allowed benefit	Not covered	100% of allowed benefit
Inpatient Care/ Hospitalization (requires preauthorization)	90% f allowed benefit	70% of allowed benefit after deductible; 90% of the allowed benefit after emergency admission	90% of allowed benefit	70% f allowed benefit after deductible; 90% of the allowed benefit after emergency admission	% of allowed benefit

• Coinsurance – Cost sharing between you and the plan for certain services. Expressed in terms of a percentage. Percentage shown is the insurance carrier's payment amount.

• Allowed Benefit – The maximum fee a health plan will pay for a covered service or treatment. Allowed benefit is determined by each health plan.

COINSURANCE & OUT-OF-POCKET MAXIMUM

- Coinsurance:
  - Only pay based on allowed benefit not total cost of procedure.
  - Example:
    - Surgery Cost: $5,000
    - Allowed Benefit: $3,000
    - Coinsurance: $300 (In-network)

** Out-of-Network Balance Bills are not included in the OOP Max.

- Out-of-Pocket Maximum:
  - Members do not pay anything other than premiums and copays once the OOP maximum is met.
  - Example:
    - Surgery Allowed Benefit: $60,000
    - 10% equals $6,000
    - **Member does not pay above the OOP Max so member would only pay $1,000**

PLAN DESIGN QUESTIONS

HIPAA Compliance and Refresher Training

Department of Budget & Management

Office of Personnel Services & Benefits

Employee Benefits Division

2013

HIPAA - Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 was designed to protect the privacy and security of health information and provide standards for the electronic exchange of health information.

HIPAA Key Provisions

- **Portability** of insurance coverage from one job to the next job, reducing pre-existing condition exclusions (Certificate of Creditable Coverage)
- Protect **privacy** of health-related information (April 2003)
- **Standardize** electronic transmission of health-related data (October 2003)
- **Security** of electronically held health-related information (April 2005)
- Health Information Technology For Economic and Clinical Health **(HITECH)** Act (2009)

Primary Goal of HIPAA

Assure that individuals' health information is properly protected while allowing the flow of health information which promotes high quality of care and protects the public's health.

Goals of HIPAA Privacy Standards

- Provides individuals the right to obtain their health information.
- Provides strict guidelines for the release of health-related information.
- Requires Covered Entities keep health-related information secure and confidential.
- Requires Covered Entities establish clear documented policies/practices to protect an individual's privacy and protect health-related information from disclosure to unauthorized persons.

Covered Entities

Groups that must comply with HIPAA and protect the confidentiality of protected health information:

- Health Plans
- Healthcare Providers
- Healthcare Clearinghouses
- Business Associates (of Covered Entities)

Health Plans

Include health insurance companies, HMO plans, PPO plans, EPO plans, POS plans, BH/SA, Rx, Dental, company health plans and government programs such as Medicare and Medicaid.

The State of MD Employee and Retiree Health and Welfare Benefits Program and the Carriers administering it are Covered Entities.

Healthcare Providers

Conduct certain business electronically such as billing of health insurance claims - including most doctors, dentists, clinics, psychologists, hospitals, nursing homes, assisted living, adult day care, and pharmacies.

Healthcare Clearinghouses

Entities that process the non-standard health information they receive from another entity into a standard electronic format or data content and vice versa.

Example: A billing service that takes information from a doctor and puts it into a standard coded format to be sent to the insurance company for payment.

Business Associates

Performs the following services for a Covered Entity and receives PHI: legal, actuarial, accounting, consulting, data aggregation, management, administration, accreditation, and financial services.

Protected Health Information (PHI)

- All individually identifiable health information (oral, paper, electronic) that is created or received by a Covered Entity.
- Relates to past, present and future physical or mental health condition, healthcare services received, payments/premiums for healthcare.
- Shows individual identification (e.g. name, birth date, Social Security number, address, telephone number).

Protected Health Information (PHI)

- Employment records are not considered PHI.
- Health plan enrollment, eligibility or premium payment information are not employment records and are considered PHI.

Disclosure of PHI

- Under certain limited conditions, a Covered Entity can disclose an individual's PHI without written authorization.
- Under most circumstances, a Covered Entity must obtain written authorization from the individual to disclose the individual's PHI.

Permissible Disclosure of PHI Without Authorization

A covered entity is permitted to use or disclose PHI **without** written authorization for the following purposes or situations:

1) Individual requests his/her own PHI,
2) Limited data set (i.e., information is de-identified),
3) For healthcare administration activities (such as mandatory reporting, assistance with member claims and fraud/abuse investigations).

Permissible Disclosure of PHI Without Authorization

4) To carry out treatment, payment, or healthcare operations (TPO)

- Treatment: provision, coordination or management of health care by providers.
- Payment: activities of collecting premiums, providing benefits, or obtaining reimbursement, including eligibility or coverage determinations, and coordination of benefits.
- Operations: activities related to plan administration and covered functions, such as audits, quality assessments, rate setting, fraud detection, customer service, and benefit procurement.

Permissible Disclosure of PHI Without Authorization

5) To law enforcement officials when investigating and/or processing alleged or ongoing civil or criminal actions.
6) When required by law, such as to the Secretary of the U.S Department of Health and Human Services or in response to a subpoena.
7) To avoid a serious or imminent threat to health or safety.

PHI Disclosure Requiring Written Authorization

- Any use or disclosure that is not for TPO purposes
- Any use or disclosure which is not specifically authorized in the law
- Any PHI to be disclosed to a Third Party (such as your personal representative or family members)

Appeals Process: Ensure a HIPAA authorization form is completed when disclosing certain information under the new appeals process under PPACA reform.

HIPAA Safeguards

Safeguards used to prevent the improper disclosure of PHI:

- Administrative
- Physical
- Technical

Administrative Safeguards

- Security Management
  - Continually monitor policies and procedures for updates
  - Assign a security officer
- Information Access Management
  - "Minimum Necessary" Principle
  - Access to electronic PHI
- Workforce Training and Management

"Minimum Necessary" Principle

A Covered Entity must make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed for a particular purpose.

Example: Covered Entity cannot request the entire medical record for a particular purpose unless it can specifically justify why the whole record is needed. If the Covered Entity is working to resolve a specific claim issue, the only information needed is related to that specific claim issue such as date of claim, provider, and billed amount.

"Minimum Necessary" Principle

Access and Use

- Must restrict access and use of PHI based on specific roles of members in workforce.
- Must establish policies that identify persons who need access to PHI to carry out their duties.

"Minimum Necessary" Principle

Disclosures

Covered Entities must establish a policy for requests for disclosures and for routine, recurring disclosures.

DBM has developed these policies. State agencies fall under our policies. Satellite agencies must maintain their own policies and procedures.

HIPAA Authorization Form

- Valid for 12 months.
- Can be revoked at any time by the member by providing a written request.
- Form available via mail, email or downloaded from our website.
- Forms are maintained in secure files within EBD or in agency personnel files.

HIPAA Authorization Form

Employee/Retiree Date of Birth: _____

Daytime Phone Number: ( ) _____

Employee/Retiree Social Security Number: _____

Name(s) of Member(s), if other than Employee/Retiree (your Spouse and/or Dependent Children), about whom information may be used and/or disclosed:

_____

_____

B. Directions for Release

This authorization applies in accordance with my directions as checked below. I authorize the individual or company identified below in Section B.1b to release and/or use protected health information pertaining to the member(s) listed in Section A to the individual or company identified in Section B.1a. I understand that the information to be disclosed and/or used may include enrollment information, eligibility information, premium (payment) information, claims records, claims status, and patient management records, according to my directions.

CHECK ALL THAT APPLY IN SECTIONS B.1a AND B.1b:

HIPAA Authorization Form

CHECK ALL THAT APPLY IN SECTION B. 2:

B.2. I authorize the disclosure and/or use of the following information:

_____(a) any information related to a specific claim (specify date of service or type of treatment):_____

_____(b) my entire medical record

_____(c) my enrollment, eligibility and premium payment records

_____(d) Other (describe information in detail): _____

_____

CHECK ALL THAT APPLY IN SECTION B.3:

B.3. I authorize the disclosure and/or use for the following reason(s):

_____(a) for review and appeal of a claim denial

_____(b) for assistance with my plan coverages and benefits

_____(c) for assistance with my dependent's plan coverages and benefits

_____(d) for my own purposes

_____(e) Other(describe purposes in detail):_____

_____

READ SECTION C:

C. Right to Revoke:

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. To revoke the Authorization, I understand I must contact the following in writing: Employee Benefits Division, HIPAA Privacy Officer, Room 510, 301 W. Preston Street, Baltimore, MD 21201, or via fax to

HIPAA Authorization Form

appeal purposes.

I,_____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ _____

Your Signature Date

_____ _____

Signature of Witness Date

COMPLETE SECTION E FOR A LEGAL/PERSONAL REPRESENTATIVE:

E. Legal Representative: If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) on behalf of the individual signs this authorization, complete the following:

Legal Representative's Name (PRINTED):_____

Legal Representative's Signature:_____

Physical Safeguards

- Facility Access and Control
  - Limited only to authorized personnel
  - Locked entry, doors and walls
  - HIPAA cover sheets on inboxes
- Workstation and Device Security
  - must lock their computers when unattended
  - use privacy screens to limit accidental disclosure

Technical Safeguard

- Access Control
  - Limited only to authorized personnel by individual login and password
- Audit Control
  - Must monitor access
- Integrity Control
  - Ensure data is properly handled and controlled
- Transmission Security
  - Implement technical security measures that guard against unauthorized access to PHI that is being transmitted over an electronic network.

HIPAA Privacy & Security: E-Mail

- The header of an e-mail should NEVER contain any PHI (e.g. name, SSN).
- DO NOT send emails with a member's name in the subject line!
- The body of the e-mail should contain only PHI which is absolutely necessary for the communication.
  - Name
  - Last 4 digits of Social Security number
- E-mails must be kept private and secure.
  - Secure emailing requires the use of personal logon ID and password.
  - Hard copies of e-mails containing PHI should be kept secure by filing appropriately.

HITECH ACT Enforcement Rules

- Enacted as a part of the American Recovery and Reinvestment Act of 2009
- Allows broader individual rights and stronger protections when third parties handle identifiable health information.

HITECH ACT Enforcement Rules

- Expands individual's rights to access information and to restrict certain types of disclosure of PHI to health plans.
- Requires business associates to adhere to most of the same rules as the covered entities;
- Sets new limitations on the use and disclosure of PHI for marketing and fundraising; and
- Prohibits the sale of PHI without patient authorization.

Steps To Follow When Asked For PHI

- Verify the identity of the person or entity requesting PHI.
  - Is this someone who should have access to this information?
- Determine what PHI information is being requested.
  - Is this the minimum amount of information that is necessary?
- Determine if PHI can be provided with or without written authorization.

Remember: An individual who requests his/her own PHI is not limited to the minimum amount of PHI necessary.

Verification: Covered Dependents – Spouse & Dependent Children

- Verify name, DOB, SSN of employee/retiree.
- Verify name, SSN, and DOB of dependent.
- A spouse can be provided with PHI for themselves and any covered dependent (under age 18) children.
- A spouse cannot be provided with PHI on the employee without written authorization from the employee.

Example: The spouse can be provided with PHI on the amount of the spouse life insurance coverage. However, the spouse cannot be provided information on the amount of life insurance on the employee, if the employee is still alive.

Verification: Covered Dependents – Spouse & Dependent Children

- Dependent children can be provided PHI for themselves
- Dependent children cannot be provided with PHI on the employee or spouse without written authorization
- If the child is 18 or older, the employee or spouse cannot be provided with PHI on the child without the child's authorization

Example: Dependent Child is age 20 and covered under the employee's health coverage. The employee pays the monthly premiums. However, the employee cannot be provided with any PHI, including claims or doctor visits, without the child's authorization.

Verification of and Disclosures to Third Party

- A Third Party CANNOT be provided any PHI without **written authorization** from the member such as an executed Power of Attorney or a HIPAA Authorization form.
- Third Party includes: family members, personal representatives, attorneys, physicians, accountants, etc.

Verification: Agency Benefit Coordinators (ABC)

- The ABC can be provided with PHI on employee & covered dependents within that agency only.
- The ABC cannot be provided with PHI concerning medical information (such as services needed) without written authorization from the employee or covered dependent.

Verification: Benefit Plan Representatives (BPR)

- Verify BPR and benefit plan
- Verify name, DOB and SSN of employee
- BPR can be provided with PHI information for the employee and covered dependents enrolled within that benefit plan.
- BPR cannot discuss or disclose other PHI (such as services needed) on the employee or covered dependent without written authorization from the individual.

Plan Members' HIPAA Rights

All plan participants have the right to:

- Obtain a copy of PHI held by DBM or a plan within DBM's Program.
- Amend their PHI if wrong or incomplete.
- Ask for a listing of anyone receiving their PHI from DBM.
- Request DBM communicate with them in a different manner if using the address on file creates a danger to the security of his/her PHI
- Request DBM limit how his/her PHI is given out or used.
- Request paper copy of DBM HIPAA notice.

Civil Penalties and Enforcement

For violations the penalties range from $100 to $50,000 per violation, with an overall penalty limit of $1,500,000 for identical violations during a calendar year.

Criminal Penalties and Enforcement

Criminal penalties range from a $50,000

fine and up to one year imprisonment for simple violations to a $250,000 fine and up to 10 years imprisonment for offenses committed with the intent to use PHI for commercial advantage, gain or malicious harm.

HIPAA Privacy Violation Complaints

- Individuals have the right to complain of a violation associated with their PHI privacy rights under HIPAA.

- Individuals may submit a written complaint to: Employee Benefits Division, Attn: HIPAA Privacy Officer, Room 510, 301 W. Preston Street, Baltimore, Maryland 21201,

  or

  Call the Employee Benefits Division at (410)767-4775 or (800)307-8283 and ask for the HIPAA Privacy Officer.

Other HIPAA Resources

- DBM website – www.dbm.maryland.gov/benefits
- U.S. Department of Health and Human Services – www.hhs.gov/healthprivacy

HIPAA QUESTIONS

FUTURE EVENTS

- Fall Open Enrollment
- Winter Dependent Verification Audit
- PPACA Individual Mandate
- Reminder of no DP eligibility after 1/1/14

FALL OE & DVA

- ABC trainings will be late August 2013
- Health Fairs for Employees will be in September 2013
- OE will occur in October 2013
- DVA audit will occur in January 2014.

PPACA INDIVIDUAL MANDATE

- Part of healthcare reform (PPACA §§ 1501, 1502 and 10106).
- As of January 1, 2014, individuals are required to maintain minimum essential coverage each month or pay a penalty.
- More to come from EBD during Fall OE.

ACTIVE RFPs

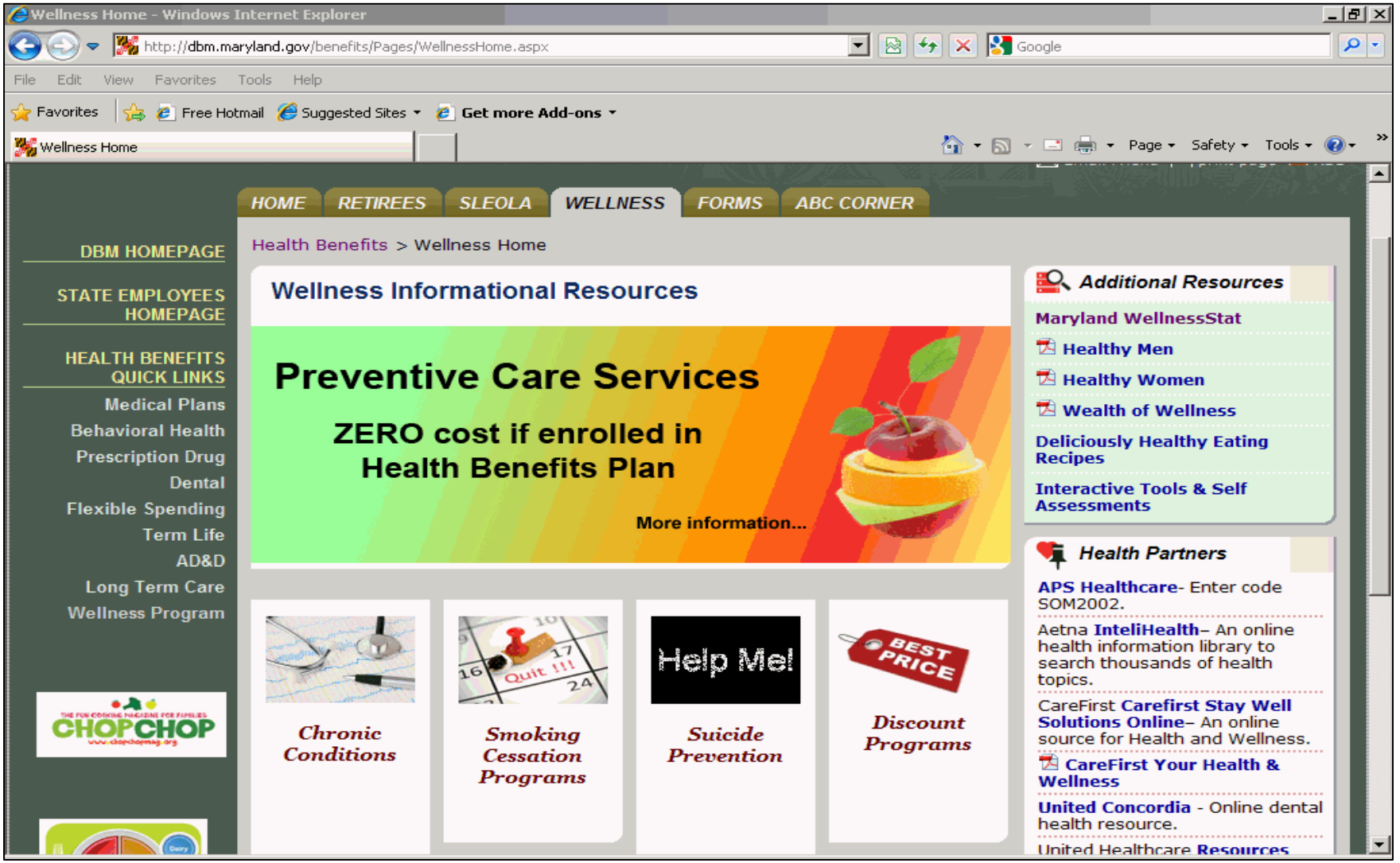
- Medical – effective 01/01/2015
- Dental – effective 01/01/2015
- SPS – effective 09/01/2014
  - Will allow for online benefit enrollment for employees
  - More clear access to enrollment records for ABCs

IMPORTANT ANNOUNCEMENTS

- EBD will be beginning an “in-house” ABC training program.
- Help us spread the word about OE – email footer.
  - Include Open Enrollment Dates
  - Include specific office hours for employee assistance

EBD email has changed. All emails are now Firstname.Lastname@maryland.gov (Kelly.Valentine@maryland.gov)

WELLNESS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HOME
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WELLNESS
FORMS
ABC CORNER
DBM HOMEPAGE
STATE EMPLOYEES HOMEPAGE
HEALTH BENEFITS QUICK LINKS
Medical Plans
Behavioral Health
Prescription Drug
Dental
Flexible Spending
Term Life
AD&D
Long Term Care
Wellness Program
Health Benefits > Wellness Home
Wellness Informational Resources
Preventive Care Services
ZERO cost if enrolled in Health Benefits Plan
More information...
Chronic Conditions
Smoking Cessation Programs
Help Me!
Suicide Prevention
BEST PRICE
Discount Programs
Additional Resources
Maryland WellnessStat
Healthy Men
Healthy Women
Wealth of Wellness
Deliciously Healthy Eating Recipes
Interactive Tools & Self Assessments
Health Partners
APS Healthcare- Enter code SOM2002.
Aetna InteliHealth– An online health information library to search thousands of health topics.
CareFirst Carefirst Stay Well Solutions Online– An online source for Health and Wellness.
CareFirst Your Health & Wellness
United Concordia - Online dental health resource.
United Healthcare Resources

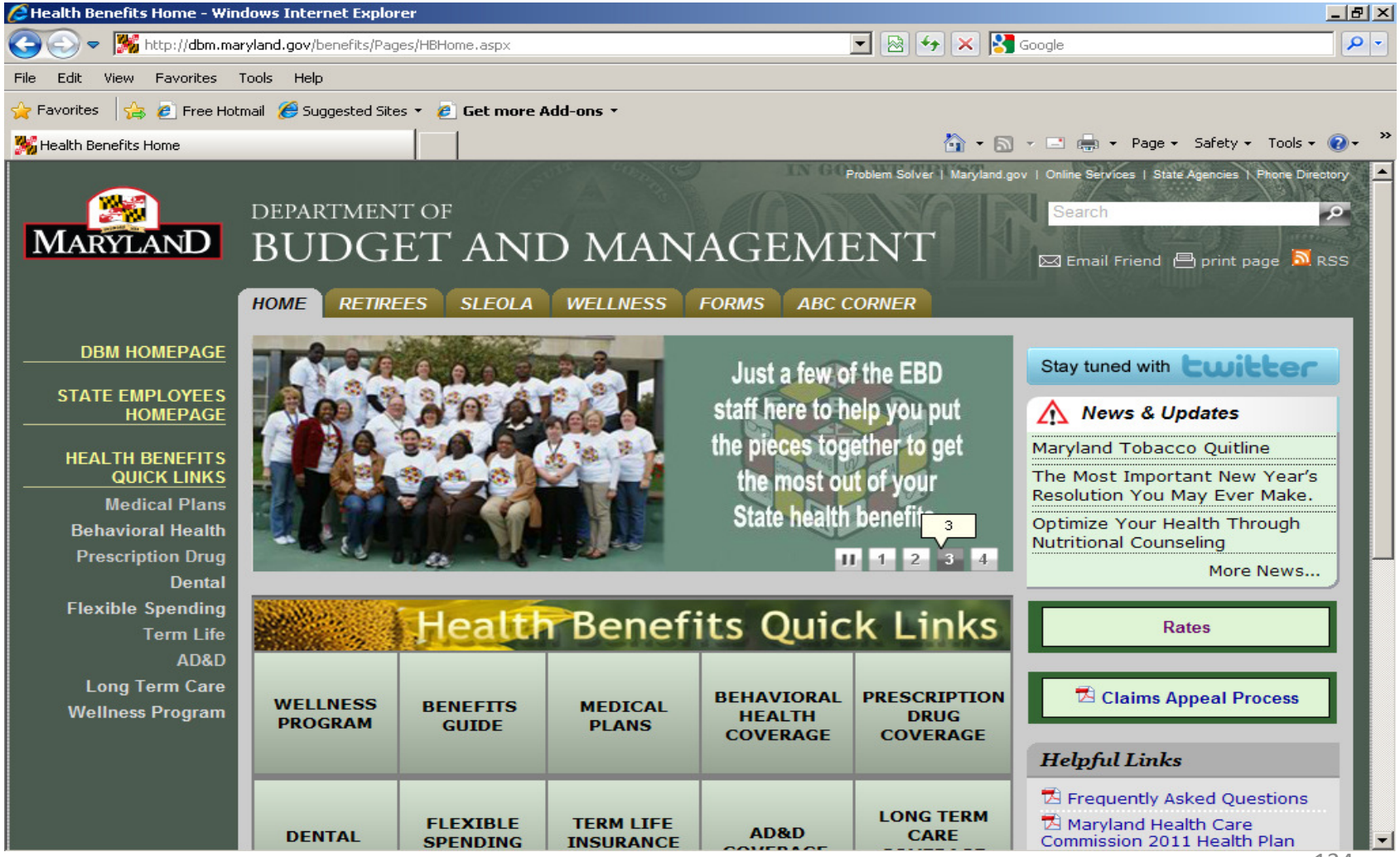
EBD – EXCELLENCE IN BENEFITS DELIVERY

- EBD supports:
  - Actives Employees – 75,000
  - Retirees – 43,500
  - Satellites Members – 3,850
  - Direct Pay Members – 2,800
- EBD manages 17 contracts.

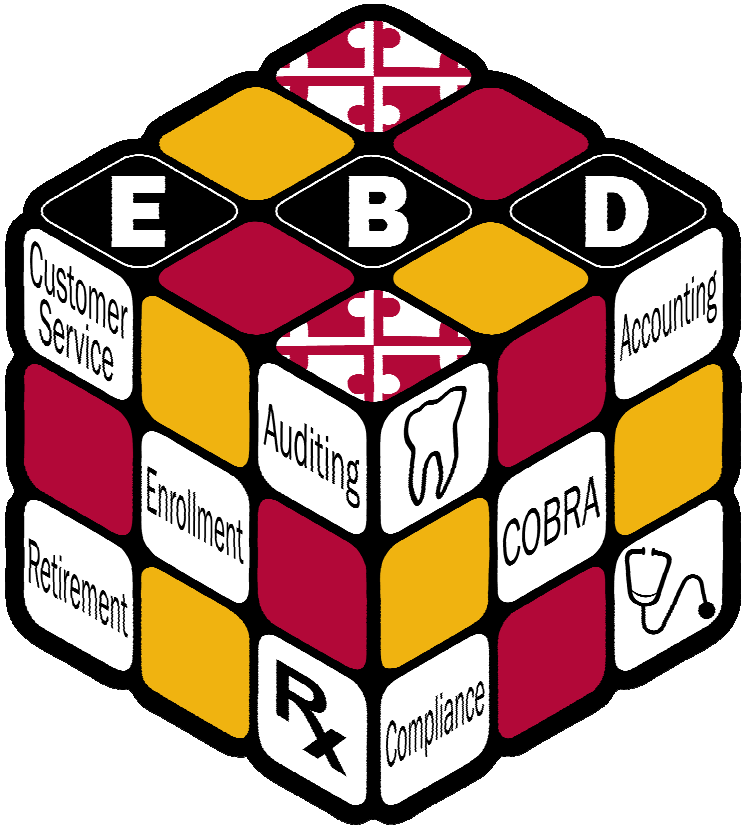
- Each Week EBD:
  - Processes over 400 forms
  - Receives at least 25 new correspondence cases or claims appeals
  - Assists over 20 walk in customers
  - Answers over 900 phone calls

DBM-EBD WEBSITE

www.dbm.maryland.gov/benefits



Thank You For Participating!



PUTTING the PIECES TOGETHER

MARYLAND

DEPARTMENT OF BUDGET & MANAGEMENT

Employee Benefits Division

301 West Preston Street

Room 510

Baltimore, MD 21201

Local: 410-767-4775

Toll-Free: 1-800-30-STATE